STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

Facility: OCCC

INMATE INJURY REPORT

NAME: KEMP, LEROY
SSN: 572-08-3824
SID: A1014031 DOB: 3-7-57

Date/Time of Report: 3/1/01 17 30
Date/Time of Injury: 2/27/01, NOON
Place Injury Occurred: REC FIELD

Description of events leading to injury by patient/witnesses:

Injury code based on this statement: 06 *

"I was running on the rec. field and tripped."

Nurse's observations/assessment/treatment of injury. **[If this injury will affect transfer, update Form DOC 0497 Health Status Classification Report]**

ambulatory slowly c limp.
(L) knee presents c moderate erythema + edema. cool to touch. Tender. 1½" x ½" abrasion @ anterior
(L) knee - healing, scab formed.

Physician/Practitioner's Examination of patient:

Plan 1) ace wrap for ambulation only
2) instructed to elevate affected leg 5 ace as much as possible.
3) Notify M.D. on-call.
orders ① motrin T.I.D PRN x 10 DAYS (#30 NR)
② ACE WRAP to affected knee

Disposition:

Back to A-1

3/1/01
Nurse's Signature/Title/Date

Examining Physician/Practitioner's Signature/Date

T.O.
Dr Zenlea

*Injury codes:
01 Inmate/Industrial
02 Inmate/Recreation
03 Inmate/Inmate (Polaroid photographs required even if no apparent injury.)
04 Inmate/ACO (Polaroid photographs required even if no apparent injury.)
05 Inmate/Self-Inflicted
06 Inmate/Miscellaneous

Original: Medical Record
Canary: HIBA (QI Injury Audit/Potential Legal Claim)
Pink: Institutional Safety Officer

DOC 0422 (3/98)

CONFIDENTIAL

EXHIBIT "A"

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

MULTIDISCIPLINARY PROGRESS NOTES

NAME Kemp, Henry
SSN 568-54-5488
DOB 3-7-57

DATE	TIME	INTAKE: HALAWA CORRECTIONAL FACILITY	PLAN
8/27/01	1415	Transferred from: OCCC	
		Admit date: 8/27/01	
		Status: (RAD) PARV Other	
		Medical chart received: (Y) N	
		Dental chart received: (Y) N	
		Allergies: NKDA	
		(PPD)/CXR: 2-12-01	
		Hep B status: →	
		Health History date: 2-21-01	
		Physical Exam date:	
		Mental Health Assessment: Y (N)	
		Self-admin form signed: (Y) N	
		Copayment form signed: (Y) N	
		HSCR: →	
		Medical/Psych History: Seizure disorder.	
		Medications received: Phenobarb (12 tab) 60 mg. Zoloft, Neurontin (self admin)	
		FOLLOW-UP NEEDED	WT: 189 HT: 5'10"
		Dental: Screen (Exam) Other	
		Mental Health: (Assessment) Other	
		Medical: RTC - 11/23/01; Needs Phenobarb & Neurontin renewed; Zoloft renewal. Hep B/C screen, HSCR.	
		Disposition: Mod IB — Recommended	

DATE	TIME	Psychiatry PLAN
8/28/01	(D)	Met c pt this am for 1st time, chart reviewed. Pt new to HCF from OCCC, here for a period of several yrs. likely. Pt c a history of Seizure D/O, as well as Major Depressive episodes (c suicidality in 1992, p. death of both parents). Currently pt. stable and making the adjustment to HCF, but requests to be put back on his Zoloft, which he feels helps c his moods.
		MSE: Alert, oriented, good eye contact, Speech nl. R/V/C, Mood looks happy, Affect smiling - but sl. labile. Pt. reports some anxiety which shows itself c " . Thoughts linear, logical. ØAH/VH ØSI or HI. Cognition grossly intact, I/J fair to good.
	(A) (P)	① H/O Major Depression - Stable on Zoloft 100 mg daily.
		② Seizure D/O, c recent history from 8/01.
	→	Renew Zoloft 100mg PO QHS. x 90 days.
		RTC PRN probs. Currently making adjustment okay. Don Hut. DO
8/28/01	1200	Instructed Pt access to care. Hep B/c screen done. HSCA c restrictions Seizure disorder since 1992. H/t injury Pt has had multiple injuries. - GSW while in military; grenade injury. Partial amputation of (R) thumb - States he has 2 college degrees. Appears in good spirits. Concerned about his medications. Needs renewals on Neurontin & Phenobarb. will discuss this c Dr. Pideres. — H —
		Add.: scheduled for clinic for c/o knee pain s/t fall from telephone pole. Needs knee brace + will need refill on Motrin. — H (signed 9/8/01 c Dr Young)

KAPI'OLANI MEDICAL CENTER
At Pali Momi
98-1079 Moanalua Road
Aiea, Hawaii 96701

NAME: **Kemp, Leroy W**
MR #: 18-51-24 ROOM #: 4TH 04090A
DICTATED BY: Leah Ridge, MD
ATTENDING PHYSICIAN: Frank Williams, MD

CONSULTATION REPORT

cc: Leah Ridge, MD
Frank Williams, MD

DATE OF CONSULTATION: 10/16/2001

REASON FOR CONSULTATION: Breakthrough seizure. Patient is a 54-year-old, right-handed male, who tells me he has had a seizure disorder since 1997. Per history, he had a history of a significant fall with head trauma in 1995, as well as many previous head traumas during his younger years and while in Vietnam. He denies any seizure prior to 1997. He has multiple sequelae, however, of Dilantin, to include gingival hypertrophy and facial chloasma. He was admitted 10/15/2001 for apparent seizure. Per his report, he states he had the seizure because he did not take his Dilantin on time due to a "lock-down due to a hanging at prison." States that his seizures are typically very well controlled with phenobarbital. Review of the ambulance report shows there was a *grand mal*-type seizure per medical staff. However, patient remained responsive throughout and no postictal period. There was also no incontinence. EEG done today, which I interpreted, was a normal study without any evidence of a seizure focus.

PHYSICAL EXAMINATION: Patient had a temperature of 97°, pulse 53 and regular, blood pressure 128/72, respiratory rate 20. He was alert and oriented to person, place, time, and purpose with marked sinus bradycardia to 49 on EKG. CK level was normal. Sodium was normal. Glucose was normal. Calcium, creatinine, and CK were all normal. Phenobarbital level was 21.8 on admission. White blood count was normal at 7.2. Normal hemoglobin, hematocrit, and platelets. Normocephalic and atraumatic, other chloasma, as noted above. Neck: supple, full range of motion. There were no bruits detected. Extraocular movements were intact. Pupils: equal, round, reactive to light and accommodation. Visual fields were full to confrontation. No ptosis or nystagmus. V1 through V3 sensation was intact. Corneas were present bilaterally. He had full facial excursions with strong eye closure. He was able to hear finger-rub at 6" bilaterally. Sternocleidomastoid and trapezius muscles were 5 for 5. Tongue: midline with good protrusion. Strong cough, gag, and no dysarthria detected. On motor examination, 5 for 5 with normal tone. Deep tendon reflexes were 1 plus and equal. Finger-to-nose was normal. He had normal sensation times four. Gait was not tested due to patient's being handcuffed to the bed and he had very significant gingival hyperplasia.

IMPRESSION: Possible seizure disorder, although the event on admission of a *grand mal* event with no loss of consciousness sounds more like a pseudoseizure. He is on phenobarbital as an outpatient. I discussed with the patient the fact that I did not think this was a good medication for him due to the known side effect of long-term memory loss while on this medication for many, many years. He does not want to go on Dilantin and I also think he has already demonstrated significant sequelae from this medication. I discussed Lamictal with him and told

Doc# 196040

ORIGINAL

10/22/01

KAPIOLANI MEDICAL CENTER
At Pali Momi

NAME: Kemp, Leroy W
MR #: 18-51-24

CONSULTATION REPORT

him he would probably have fewer side effects on this medication, and that it would take approximately three months to get him up on the required dose, but that at that time we could discontinue phenobarbital and I felt he would feel mentally more clear on that medication. EEG, CT, and examination otherwise are within normal limits. We will place the patient on neuro checks and I guess there is obviously a question of pseudoseizure in this patient and I think it is important when he does get back to prison to establish at least a history that can be transmitted to physicians in the future of any generalized events with loss of consciousness, as opposed to only those without.

Thank you for this referral.

Leah Ridge, MD

D: 10/16/2001 6:53 P T: 10/16/2001 10:46 P LR/jb
Job #: 000027983 Doc #: 196040

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

INFIRMARY PROGRESS NOTES

NAME Lemp, Leroy
SSN 568-54-5488
DOB 3/7/57

DATE	TIME	INFIRMARY DISCHARGE PLAN
11-1-01		1. Discharge from Infirmary: Medical
		2. Diagnosis: Pseudo seizure
		3. Diet: Regular
		4. Activity: As tolerated
		5. Special Needs: Seizure precautions
		6. Medications: 1) Indocin 50 mg po tid prn pain x 4 wks; all meds 2) Phenobarbital 120 mg q AM & q HS; and admin. 3) ~~Zoloft 30 mg q NOON x 4 wks~~ 3) Start Tegretol 200 mg bid x 2 wks.
[illegible] 11/2/01 [illegible]		
		7. Medical Discharge Summary: After yesterday's discussion with Dr. Rudge (487-7960) will treat pt's pseudo seizure with Tegretol and wean off Phenobarb due to the cognitive effects. Explained this to patient who has not had a seizure since this admission. Pt appears to understand and is agreeable. Okay to D/C pt from Infirmary
11/2/01 noted 1245 [illegible]		8. Follow up/Appointments: 1) CBC c diff prior to Tegretol initiated. 2) CBC c diff & Tegretol level 1 ~~wks~~ wk after Tegretol initiated. 3) Schedule pt for Chronic Care Clinic after 4 wks c 1) ~~CBC~~ Comprehensive Metabolic Profile 2) EKG and 3) Lipid profiles. [signature]

DOC 0483 C (9/99)

CONFIDENTIAL

HCF00272

DATE	TIME	PLAN

CONSULTATION RECORD

Facility: HCF

S.I.D.: P6210/4031

Name: Last: KEMP First: LEROY Initial:

DOB: 3-7-57 SSN: 568-34-5488

REQUEST TO: DR. LEAH RIDGE

DATE OF APPOINTMENT: 1-15-03

TIME: 1315

REASON FOR CONSULTATION:

F/U ER VISIT

Date 8-26-02

Requesting Physician: Robert Young M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS) Meds - PB = 60 tid Tegretol - 200 tid

3/19/03 ER follow-up BP: 132/86 P: 82

[illegible]

M.D.

Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

F/U 5 weeks. [illegible]

Okay to follow above 03/19/03

[illegible] RN 3/19/03

Original: HCU

Yellow: Consultant's Copy

DOC 0406 (11/97)

CONFIDENTIAL

HCF00605

Facility _____ RTC _____

Chronic Care Clinic Follow-up Visit

Name Kemp, Gene Sex M

SSN 568-54-5488 SID A1014031 DOB 3-7-57

Allergies None known

Diagnosis: Seizure D/O; Post HCV Rx.

Tests needed prior to visit

Current Medications: Phenobarbital 60mg TID, Tegretol 200mg TID
Lamictal 150mg BID (from outside MD)

Diet

Special Needs: Knee brace

SUBJECTIVE DATA

Complaints/Comments: c/o lump 2 to 3 months on (L) side of head; currently experiencing aura, no seizure; still working in kitchen, to do duty

Review of Symptoms: Will be going to Reno/Tahoe (@ Harrah's) in May 03. Wants snacks because of meds; Takes ibuprofen in afternoon for (L) knee.

Compliance with medications: Y N/A

Effectiveness of medications

OBJECTIVE DATA

Vital Signs: Ht. 5'10" Wt. 190 B/P 130/78 P 80 R 18 T 98.6

Skin: Malar hyperpigmentation otherwise benign.

HEENT: Normocephalic; (L) parietal/occipital abscess, early 1" x ½", post auricular.

Heart: WNL

Lungs: WNL

Extremities: Walks c reinforced (L) knee brace; gait abnormal; (L) knee abscess more distorted.

Other

Evaluation of labs, tests, treatments, consults

Note: Reviewed Dr. Riley's note of 3/19/03

ASSESSMENT

DOC XXX

1) Seizure, [illegible] seizure
2) Deformed (L) knee, unstable, surgical candidate ?
3) Early abscess, (L) scalp, occipital.
Dg

PLAN

Medications 1) ~~Phenobarb~~ Phenobarbital 90 mg ~~tid~~ bid x 3 month
2) Tegretol 300 bid x 3 month.
3) Lamictal 150 mg ~~qd x~~ am bid x 3 month
4) Keflex 500 mg tid PO x 10 days.

Labs

Treatments Start treatment sheet for administering anticonvulsants, pt to initial it if received his med. x 3 month.

Consults 1) Return to Dr. Leah Rodge in 8/03
2) Return to Dr. Varona for re-eval of (L) knee in 4/03.

Diet Low fat, low cholesterol diet x 3 month.

Special Needs

Other (L) knee brace c̄ metal stays.

EDUCATION AND COUNSELING

Briefly spoke to pt about using snack to treat dyspepsia fr medication.

noted 3-24-03 1740 [illegible]

Return to Clinic 90 days ✓ Other PRN Signature/Title [signature]

Update: Problem sheet ______ HSCR ______ Date 3/24/03

DOC XXX

24° 3/25/03 0015 mg MAR

HCF00551

PAST MEDICAL HISTORY: Head trauma, seizure disorder.

ALLERGIES: I do not have a record of his drug allergies.

SOCIAL HISTORY: He is currently a nonsmoker and a nondrinker, and does not use recreational drugs per his report. He is currently a Halawa Prison inmate.

PHYSICAL EXAMINATION: He was alert and oriented to April 2003, he was unable to tell my the exact date. He was unable to tell me the name of the president. He had good abstraction. He was very cooperative and pleasant during my examination with good immediate recent memory and naming other than the president which I did feel was real. He appeared to be very cooperative. He was however, able to discuss the fact the he believed we should be in this war in Iraq and the reason for that being that me as a female doctor would have to be covered by a burka, that women should have equal rights, and that all people should have religious freedom. He denied any recent fever or any other seizures since we last saw each other in the last month or so. Motor and sensory were at baseline as were speech and swallow. O2 saturation was 98%. Blood pressure: 138/74. Respirations: 20. Pulse: 126/minute. Temperature: Afebrile. NEUROLOGICAL: Cranial nerves 2-12 were tested and found to be within the normal limits with the exception of the left eye palpebral fissure approximately 1 mm more ptotic than the right. Motor: 5/5 with normal tone. Sensory: Intact to light touch, pinprick, and vibration. Deep tendon reflexes 1+ and equal. Finger-to-nose was normal. Gait is not tested. NECK: Slight decreased range of motion at approximately 80%, was supple.

IMPRESSION: Forty-six-year-old male seen by myself in the past with known seizure disorder as well as a history which is consistent with pseudoseizure. He appears to have had a combination of the above seizures and pseudoseizures today. I was unable to actually see any of the events, but I did trust Dr. Dinora Gil's workup report that there was a real seizure in the emergency room and later on a pseudoseizure. He also has some laboratory changes and tachycardia too to suggest that he was perhaps having real seizures prior to coming today. This was also substantiated by his subtherapeutic phenobarbital and Tegretol levels.

When I last saw him in my office, he was actually therapeutic on his medications. We do not have records of actual dosing of the medications in the emergency room so we will attempt to make some changes consistent with the information that is available. I had initially put him on a titration schedule for Lamictal and he states that he is currently taking 150 mg b.i.d. There is no obvious rash on his body so I will increase that to 175 mg p.o. b.i.d. His Tegretol level was subtherapeutic on admission. He states he is taking 200 mg of Tegretol t.i.d., I will change that to 200 mg two tablets in the morning and two tablets in the evening. Phenobarbital, he states that he is taking 60 mg t.i.d. He and I were in the process of weaning him off of the phenobarbital and trying to control his seizures with only Tegretol and Lamictal. So, I will decrease the phenobarbital to 30 mg in the morning and 90 mg at night. When he goes back to prison, this can be later discontinued and Tegretol and Lamictal can be increased to cover. I anticipate that he will need 175 mg b.i.d. to 200 mg b.i.d. of Lamictal and with the Tegretol, we are now going up to 400 mg b.i.d. and this may be necessary to increase perhaps even to 500 mg b.i.d. depending on levels obtained in the future, and I will follow while here in the hospital.

264514

ORIGINAL

4/23/03

KAPI'OLANI MEDICAL CENTER
At Pali Momi

NAME: Kemp, L
MR #: 18-51-24

CONSULTATION REPORT

Leah L Ridge, MD

D: 04/06/2003 7:10 P T: 04/06/2003 8:07 P LLR/nr
Job #: 000000884 Doc #: 264514

4/23/03

264514

ORIGINAL

CONSULTATION RECORD

HCF
Facility

A1014031
S.I.D.

Name: Kemp, Leroy (Last / First / Initial)

DOB: 3/7/57 SSN: 568-34-5488

REQUEST TO: Dr. Leah Ridge

DATE OF APPOINTMENT: 5/7/03 TIME: 1145

REASON FOR CONSULTATION:
SWK F-up

(lamictal - 200 mg b
tegretol - 250 mg b)

Date 3/19/03

Requesting Physician Dr Paderes/MW M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

States he had a seizure 2 weeks ago
no rash - feels much better on this
regimen - States he hurt his arm
A&OX4.
2012 ne -
515 NE he quit

Imp - Seizure disorder c pseudoseizures
I think his medical condition
is much better controlled c
current meds. He will need
to have his (L) leg reconstructed
I will give names for orthopedics
surgery -
√ tegretol level today +Nat
(will call if adjustment needed)

[signature] Consultant's Signature M.D.

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU
Yellow: Consultant's Copy

F/U as needed.

DOC 0406 (11/97)

CONFIDENTIAL

CONSULTATION RECORD

Facility: HCF
S.I.D.: P6210/4031

Name: Last: KEMP First: LEROY Initial:
DOB: 3-7-57
SSN: 568-54-5488

REQUEST TO: DR LEAH RIDGE
DATE OF APPOINTMENT: ~~7-18-03~~ 9.22.03
TIME: ~~1630~~ 1500

REASON FOR CONSULTATION:
F/U SEIZURE DISORDER
lamictal 200mg bid
Tegretol 250 bid

Date 5.7.03
Requesting Physician Gary Saldana M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

- last tegretol level 10.7 + Nat 141
Had eval by Dr Oishi who wants to do a total knee replacement –

⇒ A+O x4 → neuro (5) –
2→12 nl →
5/5 nl – FTN
– antalgic gait ↓ (L) knee [illegible]
Can get up on (R) foot

Imp – Seizures (Pseudoseizures – tolerating his current regimen. ? if all are real but I do believe he has real seizures

Plan – cont lamictal – 200 mg bid
tegretol – 250 mg bid
F/U as needed
[illegible]

[signature]
Consultant's Signature M.D.

HCF00905

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU
Yellow: Consultant's Copy

DOC 0406 (11/97)

✓ tegretol
✓ Nat level
today.

Ok to follow above.
No need to do F/U @ this time. 9/23/03

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STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

INFIRMARY PROGRESS NOTES

NAME Kamp, Leroy
SSN 568-54-5488
DOB 3/7/57

DATE	TIME	INFIRMARY DISCHARGE PLAN
8/1/03	1310	1. Discharge from Infirmary: Medical
		2. Diagnosis: pseudo seizure
		3. Diet: regular diet
		4. Activity: as tolerated.
		5. Special Needs: seizure precaution. No top bunk.
		6. Medications: follow current med. order.
		7. Medical Discharge Summary:
		46 y/o ♂ admitted yesterday due to seizure in PM. Pt has been seizure free since yesterday and currently asking to be discharged. Pt is alert, oriented & in NAD; Prolactin level drawn yesterday (normal). Okay to discharge pt c̄ pre-admission meds.
noted [illegible] 8/1/03 1310		
		8. Follow up/Appointments:
		RTC prn. [signature]
24° ✓ 8/2/03	0640	

HCF00837

DOC 0483 C (9/99)

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DATE	TIME	PLAN
7/31/03	1600	Admitted to infirmary s/p pseudo-seizure. Responds to verbal stimuli. Moves all extremities. Oriented to name and place. On psyche side room #6. sleeping/lying on mattress now. On sz precaution. Prolactin level drawn.
		Rhenz I. Ilonta, RN
7/31/03	1845	S: I have double vision
		O: A/O x 3. Able to push self up to standing position but done it slowly. Ambulated to the cell door to take his medications. States he did not eat his dinner well. ⊖ sz noted. ⊖ tremors.
		A: Sz
		P: Called kitchen to order his dinner. Cond on sz precaution.
		Rhenz I. Ilonta RN
		Addendum: Prolactin level 5.5 (2.6 - 13.1 normal range) per lab.
		Rhenz I. Ilonta RN
		8-1-03 Friday
8-1-03	2200-0500	sleeping / lying on mattress floor. respirations noted q1° visual ✓
		[illegible]
8-1-03	0930	S/O I'll take my meds so I can go I don't want to be here I'm okay. I don't like it here. I/M expresses that he want to go back to his module
		A/P Stable at this time cont to monitor — A Palafox LPN
8-1-03	1345	I/M ambulated to Module without any problem ∅ s/s of discomfort of any kind. in the past 24°. —
		A Palafox LPN
8-1-03	1600	S: ∅ complaints.
		O: A&Ox3. in cell eating dinner - 100% BW/V. asking when he is going to leave to go back to the modules. calm. ∅ sz activity noted.
		A: stable
		P: Discharge to Module by wheelchair ē floor boy escort @1600.
		[illegible signature]

HCF00839

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

INFIRMARY PROGRESS NOTES

NAME EMP, LEROY
SSN 568-54-5488
DOB 03-07-57

DATE	TIME	INFIRMARY ADMISSION PLAN
7/31/03	1607	1. Admit to Infirmary: (Medical)
		2. Diagnosis: Post Pseudo seizure Episode
		3. Diet: NPO, Clear liquid, _____ cal ADA, (Regular) DAT
		4. Intake and Output: (N/A) Q4h, Q8h
		5. Vitals: (Q shift) Q 4 hours, Q day
		6. Activity: (As tolerated) Bedrest, Ambulate with assist
		7. Condition: stable
		8. Allergies: NKDA
		9. Labs: PROLACTIN SERUM x 1. done RI
		10. Special Needs: Knee brace & Cane
		11. Parameters:
		12. Medications: 1) Tegretol 200 mg bid 2) Lamictal 200 mg bid
		13. Medical Admission Summary:
		45 yo o/ c hx of Pseudo seizure Disorder had an unusual seizure this afternoon. Pt had punching motion when seizing to urinary & bladder fecal incontinence, no post ictal lethargy.
		14. Medical Treatment:
		Admit pt to Infirmary for overnight observation.
		24 hr 1.07 q 4 hr

HCF00838

CONFIDENTIAL

Facility _____ RTC _____

Chronic Care Clinic Follow-up Visit

Name Kemp Leroy Sex M

SSN 568-54-5488 SID A1014031 DOB 3/7/37

Allergies NKDA

Diagnosis: Seizure disorder

Tests needed prior to visit: Tegretol level

Current Medications: Lamictal 200 mg PO BID
Tegretol 500 mg BID
Motrin 800 mg 1 PO TID

Diet: reg MAR

Special Needs:

SUBJECTIVE DATA

Complaints/Comments: Still wants to have TKR for (L) deformed knee. Last seizure was 8/03 (Prolactin level was benign)

Review of Symptoms: Except for (L) knee limitation.

Compliance with medications: (Y) N

Effectiveness of medications: Fair (?)

OBJECTIVE DATA

Vital Signs: Ht. Wt. B/P P R T

Skin: Warm & good turgor

HEENT: Normocephalic - PERRL

Heart: RSR S1 (NL) S2 (NL)

Lungs: Clear to auscultation

Extremities: See below; rest of extremities benign. Ganglion cyst (L) foot

Other: (L) knee 15 3/4" @ mid patella; severe varus deformity; ↓ ROM; no effusion

Evaluation of labs, tests, treatments, consults

Tegretol 8.1 12/29/03.

HCF00842

ASSESSMENT

DOC XXX

1) Pseudo seizure - no seizure since 8/03; stable

2) (L) knee deformity ± joint degenerative joint disease. ± progressive deformity.

PLAN

Medications 1) Continue meds x 3 months.
2)

Labs None @ this time.

Treatments Weight pt @ staff 2 wks x 3 months.

Consults None @ this time.

Diet Regular ± HS snack.

Special Needs Wheelchair x 3 months; MTM. ± knee brace ± medical shoes.
Medical Pass x 3 months.

Other

1-5-04

EDUCATION AND COUNSELING

Return to Clinic 90 days ✓ Other 4/1/04 PRN

Update: Problem sheet _____ HSCR _____

Signature/Title _____

Date 1/5/04

HCF00843

DOC XXX

CONSULTATION RECORD

(PG2101403,)

HCF
Facility

A1014031
S.I.D.

KEMP, LEROY W
Name Last First Initial

3-7-57
DOB

568-54-548
SSN

REQUEST TO: Calvin Oishi, MD

DATE OF APPOINTMENT: 6-30-03

TIME: 1045

REASON FOR CONSULTATION:
↑ unstable (L) knee c lat. deviation and pain
eval re: treatment recommendations, risks

Date 6/25/03

Requesting Physician [signature] M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

- Progressive pain left knee
- s/p Bone on Bone
- For (L) TKA (Total knee replacement) on 7/31/03
- Book Return for H&P.

7/2/03

[signature] M.D.
Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU
Yellow: Consultant's Copy

DOC 0406 (11/97)

SURG - approved
NOT - Due to ability to work, wt. bear c brace and early age for T.K.R.
Re-evaluate clinically as needed

Notified pt 7/2/03

CONFIDENTIAL

HCF0058

Refer to Surg

CONSULTATION RECORD

Halawa Med.
Facility

A1014031
S.I.D.

Kemp Leroy
Name Last First Initial

0307-57 568-545
DOB SSN

REQUEST TO: DR Calvin Oishi DATE OF APPOINTMENT: TIME:

REASON FOR CONSULTATION:
Eval of (L) knee (send c x-rays if possible)

Date 5-7-03 Requesting Physician Saldana M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

Discussed @ SURP; referral denied because surgical intervention not needed @ this time. Pt is an athlete & functioning adequately.

5/14/03 M.D.
Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU
Yellow: Consultant's Copy

5/14/03

HCF00585

DOC 0406 (11/97)

Mailed 5/14/03

24 hr 5/14/03 CONFIDENTIAL

2348

CONSULTATION RECORD

HMSF
Facility

A1014031
S.I.D.

Kemp Leroy
Name Last First Initial

03-07-57
DOB

568-54-5
SSN

REQUEST TO: Dr. Vemay

DATE OF APPOINTMENT: 5/5/03

TIME: 0900

REASON FOR CONSULTATION:
Reevaluation of (L) Knee April 2003

Date 03-24-03

Requesting Physician Paderes / BSC M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

S: CONTINUE

O: VITAL X-RAY UNCHANGED

A: NO CHANGE

P: AS BEFORE.
(1) CBC TOTAL
(2) SUGGEST REFERRAL TO ORTHO SURGEON WHO DOES ORTHOTOMY (PROBABLE HIGH TIBIAL OSTEOTOMY)
(3) F/U PRN.

Also need to schedule discussion.

T. A. M.D.
Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

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DOC 0406 (11/97)

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HCF00586

KEMP, LEROY

MAY 5, 2003 - DOWNTOWN

WT: 185 T: 98.0 BP: 138/98 P: 84

S: The patient is seen in follow-up of old left knee varus deformity of questionable etiology, most likely old fracture with osteoarthritis of the medial compartment with old anterior cruciate ligament and lateral collateral ligament injuries (lateral capsular sign). He has continued complaints of instability. He has been given a knee brace and does his exercises. He is requesting surgery to correct his problem. He was previously told that treatment of his condition is not within my expertise.

O: Physical examination shows the left knee without swelling or erythema. He continues to have a –5° of full extension, flexion is improved to 105°. He has a positive varus deformity of the joint with increased discomfort with an varus/valgus stress placed to the joint. X-rays taken today show changes consistent with old medial tibial plateau fracture and osteoarthritic change, giving him the varus deformity.

IMPRESSION:

1. Old left knee varus deformity of questionable etiology, most likely secondary to old medial tibial plateau fracture.
2. Osteoarthritis of the left knee tricompartments with old anterior cruciate ligament and possible lateral collateral ligament injuries with positive lateral capsular sign (lateral capsular calcification or avulsion).
3. Continued subjective complaints of severe instability to the left knee.

PLAN: Continue with the brace. It is suggested the patient be referred to an orthopedic surgeon in our community who does osteotomies (probable high tibial osteotomy). Follow-up prn. Please contact me if you wish to be supplied with names of surgeons who perform this procedure.

TAV:jh

Terry A. Vernoy, M.D.

cc: Halawa

Above noted: Referred to SURD for his opinion & recommendation. Follow up has been done. No further action @ this time. 5/23/03

No need for surg.

CONSULTATION RECORD

HMSF
Facility

A1014031
S.I.D.

Name Last KEMP, First LEROY Initial DOB 3/7/57 SSN 568-54-546

REQUEST TO: ORTHOPEDIC / DR. VERNOY DATE OF APPOINTMENT: 10-23-02 TIME: 1300

REASON FOR CONSULTATION:
45 y/o ♂ c pseudoseizure disorder & mental illness is being referred for evaluation of his (L) knee. Pt (L) knee was noted to be deformed since before 5/02 when he started to c/o of the pain. Prior to 5/02 up until recent his

Date 10/11/02

Requesting Physician [signature] M.D.
SISAR M. PADERES, M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)
main concern was directed towards his seizure. Recently c his last "seizure" 10/6/02 there has been ↑ pain & ↑ deformity which the pt believes was the result of his (L) knee being bumped during the seizure. 10/9/02 I had heard the pain was a brace & medical slowly but now they seem inadequate. Please evaluate Mr. Kemp and recommend course of action from conservative to non-conservative.

Thank you

[signature]
SISAR M. PADERES, M.D.

S: AS ABOVE
O: yes dictates report
A: (1) OLD (L) KNEE VARUS DEFORMITY ? ETIOLOGY MOST LIKELY OLD FX
(2) OSTEOARTHRITIS c OLD ACL > LCL (LAT. CAP. VIEW) INJURY
(3) ↑ INSTABILITY PER PATIENT.

[signature] M.D.
Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

P: (1) CONTINUE BRACE & CONSERVATIVE CARE.
(2) CONTINUE SUGGESTED MOTION TO
(3) ACTIVITIES AS TOL.
(4) SURGICAL CONSULTATIONS NOT WITHIN MY EXPERTISE I.A.

Original: HCU
Yellow: Consultant's Copy

HCF00606

DOC 0406 (11/97)

CONFIDENTIAL

Notes: [signature]

Terry A. Vernoy, M.D.
Orthopaedic Surgery
Arthroscopic Surgery
Sports Medicine

October 23, 2002

Sisar Paderes, M.D.
Halawa Correctional Facility
Halawa Health Care Services
99-902 Moanalua Highway
Aiea, Hawai'i 96701

RE: Kemp, Leroy

Dear Dr. Paderes:

Thank you very kindly for referring Leroy Kemp, a 45 year old male inmate with a history of pseudoseizure disorder and mental illness. He is seeN for what the patient states is a deformed left knee since May of 2002 with a recent history of "seizure" on 10/6/02. He now complains of increased left knee instability and pain. He states he was held down during his seizure to prevent him from hurting himself and he experienced increased pain to his left knee. He denies previous history of knee injury. He states the brace provided by you is helpful. He complains of swelling, giving way and locking of the left knee, pain getting out of sitting positions, stair climbing, squatting and getting in and out of the van. He has been given Motrin but does not take this as he does not want to mix it with his epilepsy medications. Past medical history is positive for grand mal seizures. He denies history of diabetes, hypertension, cancer, heart disease, ulcers or surgery, he has no allergies to medications.

Physical examination shows full motion to his neck and bilateral upper extremities without pain on palpation to the neck, shoulders, elbows, wrists and hands with equal grip strength. There are no deformities. He has no midline cervical, dorsal or lumbosacral spinous process tenderness. He has full motion to the lower back and is able to sit and lay on the exam table without discomfort. He denies any bowel or bladder problems. He has excellent range of motion to the hips, right knee and ankles. The left knee shows a varus deformity to the knee joint with a –5° of full extension and flexion comfortable only to 40°. He has no effusion to the knee joint. There is mild crepitus. He has tenderness to the medial and lateral joint lines. He has minimal joint laxity, anterior drawer, or varus/valgus stressing of the joint. He has slight infrapatellar tenderness and crepitus. When standing without his brace he states he feels an insecurity or instability of the knee when he puts full weight on it and tries to externally rotate the joint. With standing without his brace there is a varus deformity to the joint however the instability cannot be recreated. The skin and neurovascular status are intact distally. X-rays taken today of the left knee, two views, show an obvious varus deformity to the left knee joint of questionable etiology, most likely secondary to old fracture of the medial compartment tibial plateau. There are also osteoarthritic changes of the intercondylar notch and patellofemoral area and an old lateral capsular sign consistent with previous anterior cruciate ligament and possible lateral collateral ligament injuries.

HCF00607

Sisar Paderes, M.D.
RE: Kemp, Leroy
DATE: 10/23/02
PAGE: 2

IMPRESSION:

1. Old left knee varus deformity of questionable etiology, most likely secondary to old medial tibial plateau fracture.
2. Osteoarthritis of the left knee tricompartments with old anterior cruciate ligament and possible lateral collateral ligament injuries with positive lateral capsular signs (lateral capsular calcification or avulsion).
3. Increased left knee instability per the patient with minimal objective instability on this exam.

PLAN: Continue the brace and conservative care. Continue Motrin t.i.d. He may continue activities as tolerated. Surgical consideration in regards to this type of knee problem is not within my expertise. He will follow up prn.

I hope the above information will be of help to you. Please feel free to contact me if you have any further questions.

Sincerely,

Terry A. Vernoy, M.D.
Orthopedic Surgeon

TAV/jh

Noted: Will refer reports to SLRP. 12/11/02
Noted: 12.11.02 1330 JW.

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

MULTIDISCIPLINARY PROGRESS NOTES

NAME: Kemp, Leroy
SSN: 568-54-5488
DOB: 3/7/57

DATE	TIME	(cont.)
1/20/04		P: ④ Resubmit pt. case to SURP committee
		⑤ Refer to Dr. S. Abbruzzese for evaluation of scalp cyst.
		⑥ RTC in one wk if sx persist.
		Rierson APRN-Rx
1/20/04		Addendum Dr. Abbruzzese, requested by this NP to reassess new finding of fluid like soft palp area to pt's left knee. Dr. Abbruzzese concur c this staff to resubmit surgical req to SURP committee
		Renew Tegretol 500mg. ī tab BID x3m Tegretol level 1/22/04.
		Rierson APRN-Rx
1/21/4		discussed w/ dr Pobares re- knee surgery.
	noted 1-21-04 1500	
1/21/4		O.K. go ahead with Total knee replacement by dr Oishi

DOC 0413 (6/92)

Noted Michael Wall, RN 2/4/04

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HCF00823

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

MULTIDISCIPLINARY PROGRESS NOTES

NAME Kemp, Leroy
SSN 568.54.5688
DOB 3/7/57

DATE	TIME	PLAN
12/17/03	1620	Discussed @ SURP. no further surgical intervention. Will continue c chronic pain conservative therapy. [illegible signature]
		A. Carwell 12/17/03 1620
12/22/03	1030	Anticonvulsants, Tegretol 500mg BID & Lamictal 200mg BID re-ordered by Dr. Abruzzese x 1 mo. ✓ Tegretol level on Monday. noted [illegible] 12/22/03 N. McCoradu, RN
		Noted. N. McCorada, RN. 12/27/03
		24° ✓ [illegible] 12/29/03 2215
12/29/03	1230	MDO: ① medical ice x indefinite V.O. Dr. Paderes/[illegible]
		✓ noted 12/29/03 [illegible] 1230
01.03.04	1600	- pt. with several MRF's delineating special needs and modifications to memos desired by pt. and pt's medical aide; some requests clearly outside of facility policy; others referred to MD (pt. has RTC - see 12-4-03 Infirmary Discharge orders. [illegible] RN
1-5-04	1700	MD CLINIC/DR. [illegible] WT: 204 HT: 5'10" BP 120/84 R: 19 P: 78
1/18/04	1900	[illegible handwriting]

OC 0413 (06/92)

HCF00825
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STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

INFIRMARY PROGRESS NOTES

NA Kemp, LeRoy
SSN 568-54-5688
DOB 3-7-57

DATE	TIME	PLAN
12/4/03	0945	**MEDICAL NUTRITION THERAPY** 37 **WT:** 195 **#** **HT:** 5'10" **AGE:** ~~5~~ 50 **YRS** **TARGET RANGES: FEMALES:** 18 TO 25% **MALES:** 12 TO 20% **BODY FAT ANALYZER:** **%BODY FAT:** 21.3 % **OVER/UNDER:** 1.3 % **BODY FAT MASS:** 41.5 # S: Cont walk P: Eval planned — Robenson, RD
12/4/03	1405	S: (L) Knee pain O: Meds taken. (L) ankle dp (+) when ace wrapped removed, cool to touch, sl pitting, (L) knee pain (+) in 4 quadrant ~~swelling~~ noted around patella. Sitting in wheelchair & wants to see MD today. Pain 10 (0-10) A: Alt in comfort P: MD to evaluate (L) knee. Continue to monitor c Xray on S) Entered Correction: OCCC in 1998. ~~8~~ Feb/01 occc then Halawa in 8/01. Denies any problem c knee prior to incarceration. O) Pt in WC, (L) knee ~~moderate~~ markedly deformed, (L) foot & ankle swelling & erythema; no tenderness. Able to move toes. A) 1) (L) knee deformity. 3) Seizure 2) (L) ~~knee~~ ankle sprain, mild. P) 1) Refer back to SICP ~~for~~ for re discussion regarding TKR 2) Ace Wraps to (L) foot x 2wks. 24°/ 12/4/03 2330 —
12/4/03	1905	O/A & Complete, vss seen by MD exam, stayed in W/C all the time, c xray to (L) knee A - Stable P - D/C discharge in tact

HCF00828

DOC 0483 (06/92) (GREEN)

CONFIDENTIAL

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

Facility: HCF

INMATE INJURY REPORT

NAME: Kemp, Derek
SSN: 568-54-5488
SID: A1014031 DOB: 3-7-57

Date/Time of Report: 11/30/03 0745
Date/Time of Injury: 11/30/03 0730
Place Injury Occurred: Mainstreet

Description of events leading to injury by patient/witnesses: **Injury code based on this statement:** 06 *

S: Walking down mainstreet. Knee gave way. Fell on knee."

Nurse's observations/assessment/treatment of injury. **[If this injury will affect transfer, update Form DOC 0497 Health Status Classification Report]**

O: Facial grimacing; unable to move knee. Groaning. Appears to be in a lot of pain. No swelling noted or ecchymosis. Has Hx of DJD + injury to (R) knee. Has had PT + has been denied total replacement by SURP committee.

Physician/Practitioner's Examination of patient:

A: Alt comfort w/ fall

P: Physician on call notified.

Disposition: Admit to infirmary (see chart).

M Kennedy RPN IV 11/30/03
Nurse's Signature/Title/Date

Examining Physician/Practitioner's Signature/Date 12/1/03
Reviewed

*Injury codes:

	01	Inmate/Industrial
	02	Inmate/Recreation
	03	Inmate/Inmate (Polaroid photographs required even if no apparent injury.)
	04	Inmate/ACO (Polaroid photographs required even if no apparent injury.)
	05	Inmate/Self-Inflicted
	06	Inmate/Miscellaneous

Original: Medical Record
Canary: HIBA (QI Injury Audit/Potential Legal Claim)
Pink: Institutional Safety Officer

HCF00926

DOC 0422 (3/98)

CONFIDENTIAL

The Queen's Medical Center
1301 Punchbowl Street
Honolulu HI 96813

PATIENT NAME: KEMP, LEROY W
MEDICAL RECORD #: 442042
ROOM #: TW5D
ATTENDING PHYS: STEIN, ALAN
REPORT: MT TRANSFER/DISCHARGE SUMMARY
JOB #: 1620790

cc: SALVATORE ABBRUZZESE, MD

DATE OF ADMISSION: 04/11/2005
DATE OF TRANSFER/DISCHARGE: 04/15/2005

DOB: 03/07/1957
PATIENT AGE: 48Y

FINAL DIAGNOSES
1. Convulsions, not otherwise specified.
2. Conversion disorder.

OPERATIONS AND/OR PROCEDURES
Video electroencephalogram monitoring.

COMPLICATIONS
None.

HISTORY OF PRESENT ILLNESS
This 48-year-old man has a history of seizure-like spells. He was referred by Halawa Prison for evaluation as to whether they were epileptic or nonepileptic. On 04/11/05, he was admitted to the epilepsy monitoring unit for continuous video electroencephalogram monitoring. Review of a prior plain video tape had strongly suggested that his events were nonepileptic in nature.

HOSPITAL COURSE AND TREATMENT
The patient was admitted on 04/11/05. Medications were tapered and within two days were discontinued altogether. Provocative maneuvers such as sleep deprivation were employed. The patient had a single seizure-like episode on 04/13/05. Behaviorally, this was extremely similar to the behavior that was reviewed on the video tape. There were no epileptiform discharges, ictal discharges or other findings to suggest an epileptic seizure basis for the event. In addition to this, throughout his entire stay, his electroencephalogram was free of any epileptiform activity.

DISPOSITION
The patient will be transferred back to Halawa Prison.

RECOMMENDATION(S)
My recommendation for seizure management is that he be on no anticonvulsants whatsoever. These seizure-like events are nonepileptic (psychogenic) in nature. I would recommend that if he does have anymore of these events, that his head be cushioned with a pillow and his body otherwise protected from injury, but other than that, no intervention be made as they are semi-voluntary in nature and will cease on their own.

MRN: 442042
LEROY W KEMP
Dictated by: ALAN G STEIN, MD

The Queen's Medical Center
1301 Punchbowl Street
Honolulu HI 96813

PATIENT NAME: KEMP, LEROY W
MEDICAL RECORD #: 442042
ROOM #: TWSD
ATTENDING PHYS: STEIN, ALAN
REPORT: MT TRANSFER/DISCHARGE SUMMARY
JOB #: 1620790

Because of the possibility that the Lamictal is being used both for anticonvulsant, as well as for psychiatric management, I will advise that upon return to Halawa he continue on the Lamictal until his psychiatrist can make statements as to whether or not he needs to continue on the Lamictal for psychiatric reasons. I stress, however, that the continuation of the Lamictal is not for seizure reasons, but instead for psychiatric reasons, and only until this can be discussed with his psychiatrist.

I discussed the nature of nonepileptic events with the patient. I recommended that psychologic counseling in terms of trying to understand the psychologic basis for these events (i.e., history of abuse, etc.) be explored, as well as more pragmatic approach of behavioral modification to find more productive ways to express any stress.

I also discussed with the patient that it is impossible for me to completely rule out the possibility that he has both epileptic and nonepileptic events. Based on what we have seen here, however, I am quite comfortable in discontinuing anticonvulsant medications. Should he have recurrence of seizure-like activity, which is significantly different than the current events, then a reevaluation may be helpful at that time.

ALAN G STEIN, MD
AGS/sc
d: 04/15/2005 08:33:26
t: 04/15/2005 08:42:58

MRN: 442042
LEROY W KEMP
Dictated by: ALAN G STEIN, MD